THE DEPARTMENT OF VETERANS AFFAIRS SUBSTANCE ABUSE TREATEMENT SYSTEM:

Results of the 2000 Drug and Alcohol Program Survey

Department of Veterans Affairs

- **Program Evaluation and Resource Center**
- **HSR&D Center for Health Care Evaluation**

Keith Humphreys, Ph.D., and Doyanne Horst, B.A.

Department of Veterans Affairs Palo Alto Health Care System
Palo Alto, California

July 2001

THE DEPARTMENT OF VETERANS AFFAIRS SUBSTANCE ABUSE TREATMENT SYSTEM: RESULTS OF THE 2000 DRUG AND ALCOHOL PROGRAM SURVEY

Keith Humphreys, Ph.D.
Doyanne Horst, B.A.

Program Evaluation and Resource Center and HSR&D Center for Health Evaluation
Veterans Affairs Health Care System
Palo Alto, California

http://www.chce.research.med.va.gov

July 2001

Table of Contents

List of Tables

List of Figures

Executive Summary

Background and Purpose: The Program Evaluation and Resource Center (PERC) conducts a triennial Drug and Alcohol Program Survey (DAPS) within The Department of Veterans Affairs (VA) health care system. This report presents results of the Fiscal Year 2000 (FY00) DAPS. At the end of FY00, the VA operated 246 substance abuse treatment programs, including 20 inpatient programs, 65 residential programs, 73 intensive outpatient programs, 85 standard outpatient programs, and 3 case-finding and early intervention teams. These programs provided information on their settings, staffing, services, and patients. To assess trends within the system, FY00 results were compared with those from prior administrations of the DAPS.

Main Findings: Inpatient substance abuse treatment programs have almost disappeared within the VA health care system; the 20 identified in the FY00 DAPS represent a decline of 89% from the 174 of such programs that existed in FY91. In contrast, the number of residential programs almost tripled over this same period, from 22 in FY91 to 65 in FY00. The expansion of lower cost residential beds partially offset the loss of about 3,000 inpatient substance abuse beds over the 1990s.

The total number of intensive and standard outpatient programs (n = 158) at the end of FY00 was 10% lower than the 176 outpatient programs identified in FY97 DAPS. This represents a reversal of significant growth in the scope and intensity of outpatient addiction services in the VA from FY91 through FY97.

Staffing data also suggested a systemwide contraction of services. At the end of FY00, 2471 full-time equivalent staff were working in VA substance abuse programs, which is approximately half of the staffing of the system at its peak in mid-FY94. Staffing cuts were evenly spread across disciplines (e.g., psychiatry, social work, psychology), and were experienced by a third of VA programs in the 12 months prior to the FY00 DAPS administration alone.

The problems of VA substance abuse patients appear to have worsened from FY91 through FY00. Although the FY00 DAPS found that long-term declines in the social stability of VA substance patients may be leveling out, most patients remain socially isolated. Further, rates of psychiatric comorbidity continued a decade-long rise in all program types from FY97 to FY00. The average program reported that half of their caseload was dually-diagnosed, compared to one-third of caseload in FY91.

The proportion of programs with waiting lists increased in all program types from FY97 to FY00, continuing a trend that began in FY94. From FY97 to FY00, the average length of waiting lists increased 83% at intensive outpatient programs and 138% at standard outpatient programs. This change may be partly due to the 13% decline in the average number of annual admissions to outpatient programs, which in turn may be driven by more patients with extensive treatment needs being cared for in outpatient settings.

The type and scope of treatment services provided within substance abuse programs appears to have changed little in recent years, with the exception of prescription of psychiatric medications, which doubled in prevalence over the 1990s. In terms of the proportion of substance abuse patients receiving psychiatric medication in FY00, outpatient programs averaged over a third of caseload, and inpatient and residential programs almost half of caseload. In contrast, opiate substitution therapies (e.g., methadone) remained underutilized and provided only to a minority of eligible patients in FY00.

Substance abuse treatment services vary substantially across VA Integrated Service Networks. For the first time since the Networks were created, there are now Networks that have no specialty substance abuse beds (inpatient or residential). Within four other Networks, waiting lists for inpatient/residential care approaches or outstrips total treatment capacity. In contrast, 6 Networks provide such treatment on demand.

Conclusions: In recent years, the problems of VA substance abuse patients have increased while the services available to them have decreased. The Veterans Millenium Health Care Act will inject $9.5 million into the substance abuse treatment system, including in the two vital areas of residential care and opiate substitution services. However, it remains to be evaluated whether this amount of funding will enable the system to recover from recent significant cuts and to care for an increasingly troubled patient population.

Introduction

This report summarizes and analyzes the results of the Program Evaluation and Resource Center's (PERC) survey of the 246 substance abuse treatment programs operated by the Department of Veterans Affairs (VA) in Fiscal Year 2000. Under the auspices of the VA Mental Health Strategic Healthcare Group, PERC conducts policy-relevant evaluations of the content, structure, and effectiveness of VA programs. This report describes PERC's triennial Drug and Alcohol Program Survey (DAPS), which is used to inform program managers, clinical staff, network directors, and policymakers about the status of the VA substance abuse treatment system.

The 2000 DAPS (see Appendix) assessed program structure, staffing, process of care, and treatment services. The 246 programs participating[1] in the 2000 DAPS were all VA programs that (1) were specifically designed to provide treatment for substance abuse patients, (2) had at least two full-time equivalent (FTE) staffing, and (3) could be distinguished from other programs because they had unique staffing, patients, clinical services, and/or policies. As in prior years, programs for substance dependent patients who also had a comorbid psychiatric disorder (e.g., "dual diagnosis" and "MICA" programs) were included in the DAPS project.

Analysis of the 2000 DAPS data is organized around the four main types of substance abuse treatment programs in the VA:

Inpatient programs provide acute, in-hospital care and may provide detoxification and stabilization services as well. Inpatient programs are typically designed to treat patients for 14 to 28 days. In FY00, the VA operated 20 inpatient substance abuse programs, of which 14 (70%) also offered outpatient/aftercare services.

Residential programs are based in domiciliaries and in on- and off-site residential rehabilitation centers. They are distinguished from inpatient programs by being less medicalized, having lower staffing levels, and longer lengths of stay. In FY00, the VA operated 65 residential substance abuse programs, of which 35 (54%) also offered outpatient/aftercare services.

Intensive outpatient programs provide more than four hours of services per day of treatment to VA substance abuse outpatients. This category comprises day treatment, partial hospital, and intensive outpatient clinic-based programs. In FY00, the VA operated 73 intensive outpatient programs, 46 (63%) of which were designed to treat patients 5 days a week.

Standard outpatient programs are clinics that provide less intensive ambulatory addiction treatment services. The VA operated 85 standard outpatient programs in FY00, most of which (60 programs, or 71%) were designed to treat patients 1 to 3 days per week.

This report is organized as follows: First, we provide an overview of program settings, structure, staffing and patients in the VA's national system of substance abuse treatment, noting how the system has changed over the past decade. Next, we describe the content of VA

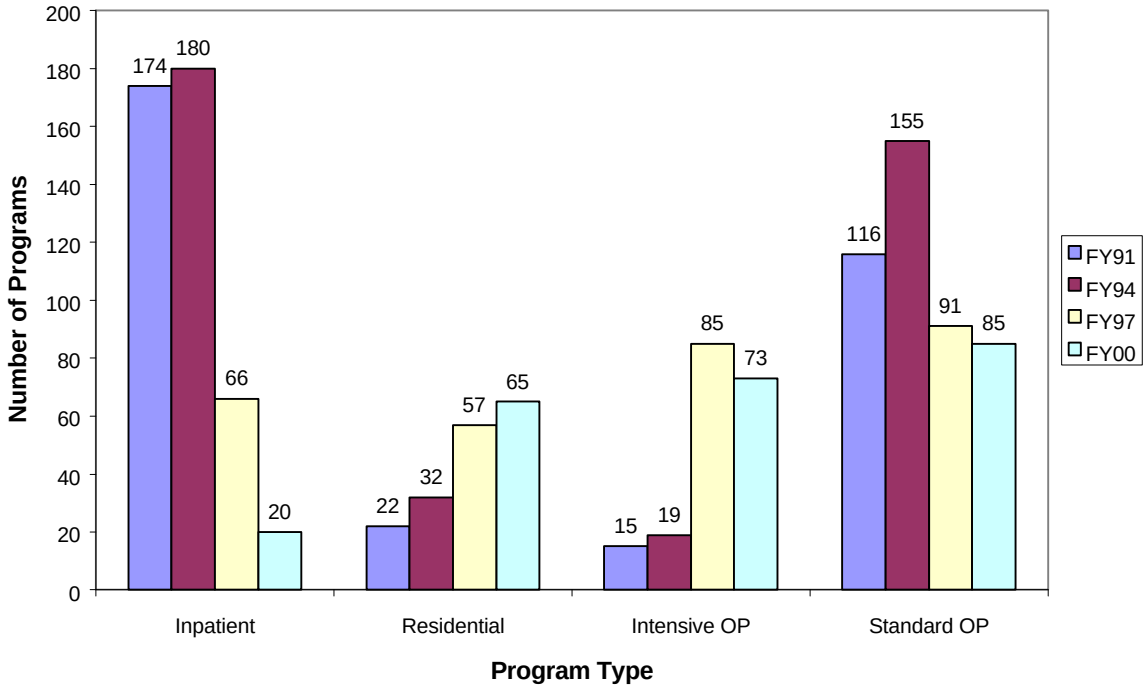
substance abuse treatment programs, including data on their accessibility and services. Finally, we describe addiction services from the perspective of each of the VA's 22 Networks, and make recommendations to strengthen the VA's substance abuse treatment system.

Program, Staff and Patient Characteristics

Overall Profile of the System, 1991-2000

Since the last DAPS was conducted in FY97, the number of VA addiction treatment programs declined by 19%, from 304 to 246 programs.[2] This reduction follows a comparable decrease of 22% in the number of programs (from 389 to 304) from FY94 to FY97. As shown in Figure 1, this contraction is primarily attributable to the 89% decrease in inpatient programs (from 180 to 20 programs) from FY94 to FY00. The decrease in inpatient programs is remarkable not only in relative terms, but also in an absolute sense: For the for the first time since PERC began monitoring VA substance abuse treatment, there are fewer inpatient programs than there are U.S. States or VISNs, meaning that this form of addiction treatment is no longer readily available to a significant number of VA system users.

Figure 1: Number of VA Substance Abuse Treatment Programs, FY91 - FY00

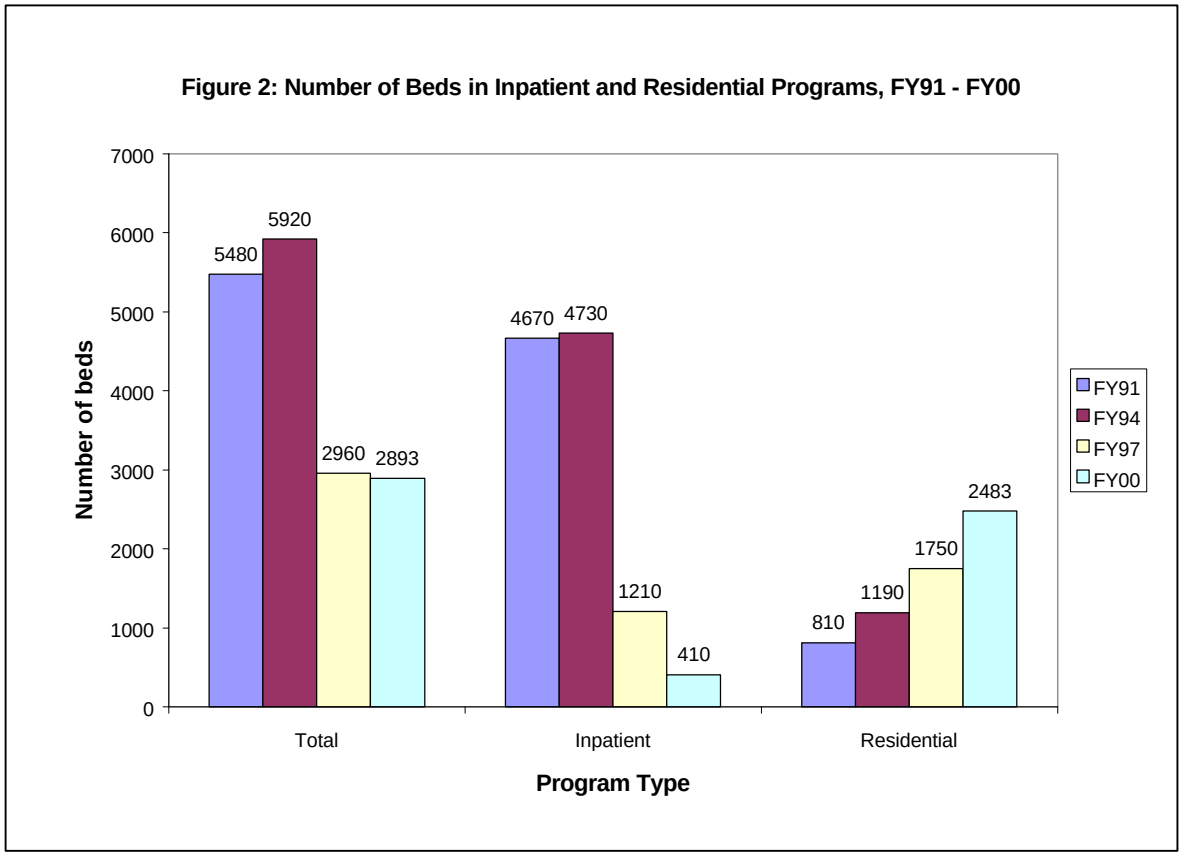


Turning to the outpatient sector, a decrease in programs is evident from FY97 to FY00, although it is much smaller than that for inpatient programs. The number of intensive outpatient programs declined by 14%, from 85 to 73 programs, and the number of standard outpatient programs declined by 7%, from 91 to 85 programs.

Viewed together, the inpatient and outpatient data indicate that the policy trends evident when the FY97 DAPS was conducted (Humphreys, Dearmin Huebsch, & Moos, 1998) continued through FY00. These changes originated in FY95 when the system was decentralized and VA facilities were given a mandate to shift their emphasis from inpatient to outpatient services (Kizer, 1996; Humphreys, Dearmin Huebsch, Moos, & Suchinsky, 1999). One indication of the sustained and significant nature of this shift is that while the number of outpatient programs in FY94 (174) was approximately equal to the number of inpatient programs (180), by FY00 there were eight times as many outpatient programs (158) as inpatient programs (20). With this transformation, the VA representative of the nation's public and private addiction treatment system as a whole, in which 90% of services are provided on an outpatient basis (SAMHSA, 2000).

The other notable change in the VA addiction treatment system is the increased importance of residential programs. In contrast to the other three program types, residential programs expanded by 14% since FY97, from 57 to 65 programs. This is a continuation of a 10-year expansion that has almost tripled the number of residential programs in the VA, from 22 to 65 programs.

The VA expanded residential addiction treatment programs in part to compensate for the loss of acute inpatient beds (Humphreys, Dearmin Huebsch, & Moos, 1998). Figure 2 provides DAPS data evaluating whether this goal was realized. From FY94 to FY97, the expansion in lower-cost residential beds was small relative to the sharp decrease in acute inpatient substance abuse beds. However, in the more recent reporting period, the "offset" was significant: The number of residential beds expanded by 733 from FY97 to FY00 while the number of inpatient beds decreased by 800. The net effect was a more modest decrease in the total number of beds, from 2960 to 2893 (2%). By FY00, 86% of VA substance abuse beds were residential, compared with only 15% in FY91. Because residential beds are significantly less expensive than inpatient beds, this change has dramatically reduced the cost of VA addiction treatment (Chen, Wagner, & Barnett, in press).

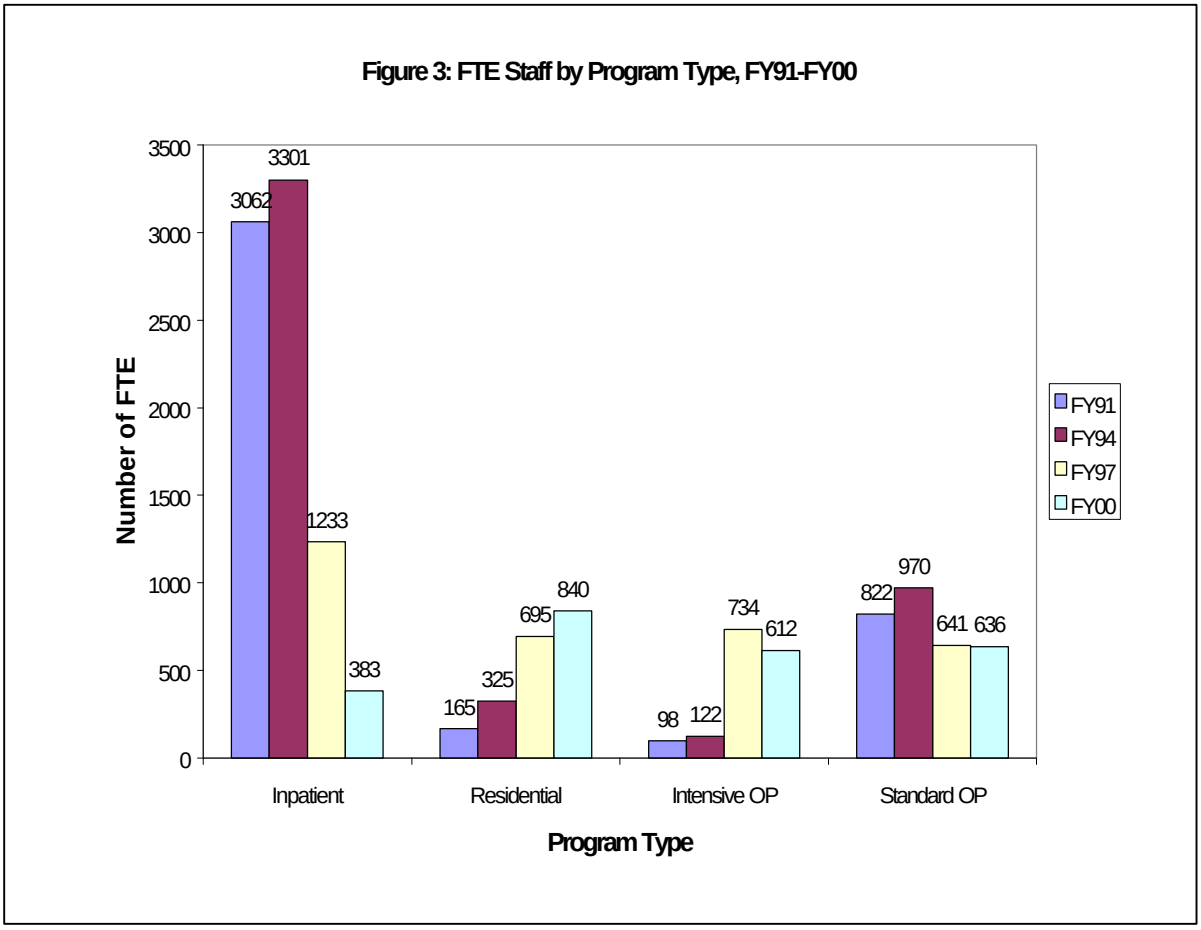


It is important to note that the Veterans Millennium Health Care Act became law shortly after the FY00 DAPS was administered. Among other provisions, the law included $9.5 million in new funds for substance abuse treatment. Any impact of these funds should be evident in future DAPS administrations, but is not reflected in the data in this report.

Staffing

Substance abuse staffing changes in the VA closely followed the programmatic changes just reviewed. The total number of FTE in the system in FY00 was 2,471, compared with 3,330 in FY97. This is a decrease of 26%, or 859 FTE, and follows a similar decrease (29%) from FY94 to FY97. The number of VA substance abuse staff peaked in FY94 at around 5,000 FTE, many of them hired through the VA's $100 million dollar substance abuse enhancement initiative (Greenbaum, Swindle, & Moos, 1993). The number of staff in the system has been declining steadily since than point continuing up to the present; One-third (33%) of all programs participating in the 2000 DAPS process reported experiencing staff cuts in the past 12 months alone.

Figure 3 breaks down staffing changes by program type. In the past 3 years, inpatient programs had the largest reduction in total staffing, from 1,233 FTE in FY97 to 383 FTE in FY00 (69%). Intensive outpatient programs suffered a small but significant decrease over the same period, from 734 FTE in FY97 to 612 FTE in FY00 (17%). In contrast, standard outpatient programs experienced virtually no change in FTE. Even though the number of such programs decreased, the total number of staff stayed constant, because standard outpatient programs employed more staff per program in FY00 (average of 7.5 FTE) than they did in FY97 (average of 7.0 FTE).



Residential programs were the only type with a significant increase of staff, from 695 in FY97 to 840 in FY00, an increase of 21%. Like the program setting data just presented, this illustrates the system's continued move towards relying on residential beds more than acute inpatient beds. Viewing the decade as a whole shows how pronounced this trend has been: In FY91, there were 18.5 FTE employees in inpatient programs for every employee who worked in a residential program, whereas in FY00 residential program employees outnumbered inpatient employees more than 2 to 1.

As shown in Table 1, VA programs employ a diverse array of professional staff. Physicians and psychiatrists, who are often employed part-time by programs, represent 4-9% of staff across program types. Psychologists are similarly represented. Across program types, nursing professionals (e.g., Registered Nurses, Clinical Nurse Specialists) are the most common type of staff. Addiction therapists and social workers are also well-represented across program types.

Table 1: Staffing in VA Programs by Position (% of FTE)

Position	Inpatient	Residential	Intensive OP	Standard OP
Physician/ Psychiatrist	7	4	7	9
Psychologist	4	7	6	8
RN/NA*	49	29	22	20
Addiction Therapist	11	19	28	21
Social Worker	5	9	11	15
Vocational Rehab. Specialist	1	3	2	2
Technician/Aide	10	10	6	4
Secretary/Clerk	7	7	12	10
Other Staff	6	12	6	11
Total	100	100	100	100

*This category includes RN, NA, Phys. Asst., Nursing Asst., LPN, LVN, and Clinical Nurse Specialist

Inpatient programs have the largest staffs (average FTE =19.2), the majority of whom are physicians, psychiatrists or nursing professionals. Reflecting their emphasis on long-term rehabilitation, residential programs (average FTE = 12.9) have the highest proportion of vocational rehabilitation specialists and technicians/aides (e.g., health, vocational, social work). Intensive outpatient programs (average FTE 8.4) and standard outpatient programs (average FTE = 7.5) have fairly similar staff compositions.

Overall, the composition of staff identified in the FY00 for each program type is similar to that found in FY97 (see Humphreys et al., 1998). This indicates that, irrespective of whether a

type of program has been growing or contracting, the impact on the employment of various professions in VA substance abuse programs has been fairly equal.

Patients

Unlike prior years, the FY00 DAPS gathered minimal data on patient characteristics because such data are now gathered through the mandated Addiction Severity Index (ASI) administration program.[3] Other PERC analyses of recent data from that program confirmed what had been indicated in prior DAPS administrations, namely that VA addiction programs serve a troubled and socially disadvantaged group of patients. For example, ASI data indicate that the typical VA substance abuse patients is dependent on both alcohol and other drugs, has additional psychological problems, and is of low income; further, 7% are homeless (Moos, Finney, Federman, & Suchinsky, 2000).

To supplement the picture provided by the ASI program, the DAPS has consistently gathered data on two characteristics: The percent of patients who are married (or living in a long-term, marriage-like relationship) and the percent who have a serious comorbid psychiatric disorder. Because being unmarried and having a psychiatric diagnosis both predict worse outcome in addiction treatment (Monahan & Finney, 1996; Stöffelmayr et al., 1987), these data provide a window on how the prognosis of VA substance abuse patients is changing over time. Trends for these indicators are summarized in Figure 4 and Figure 5.

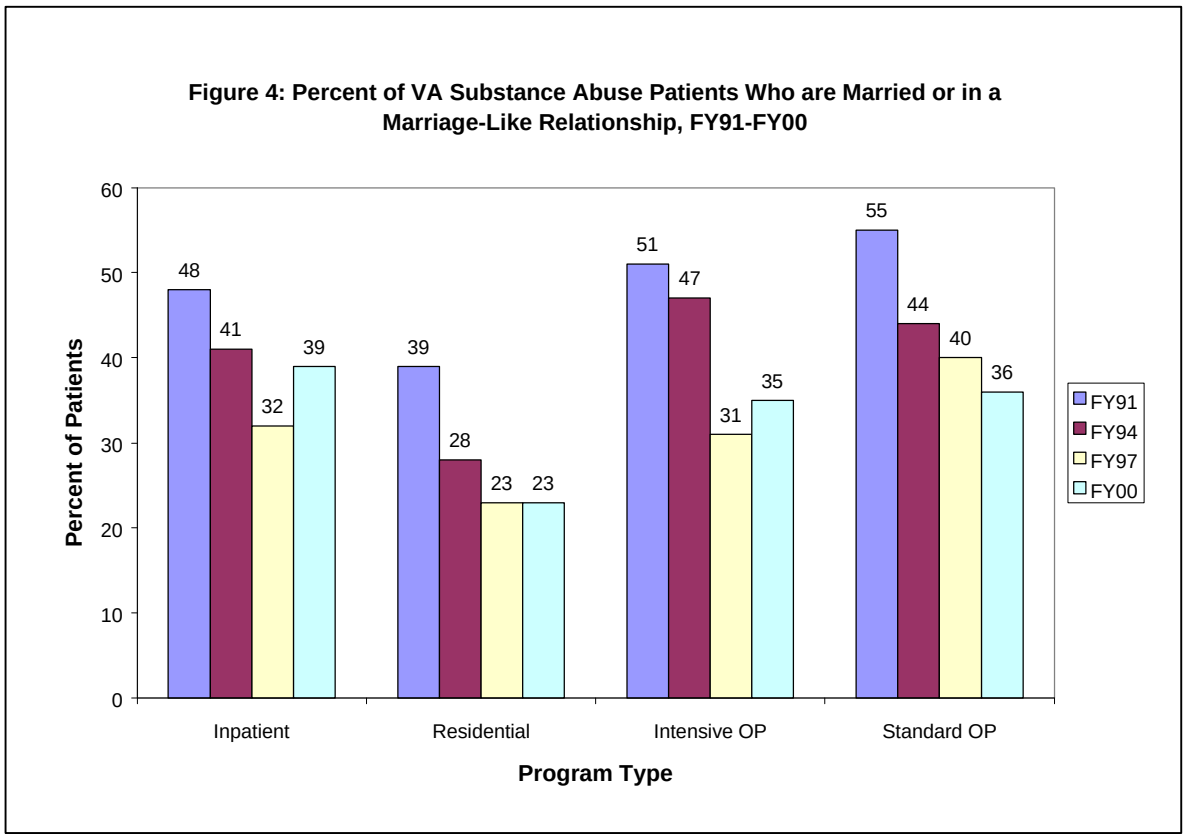
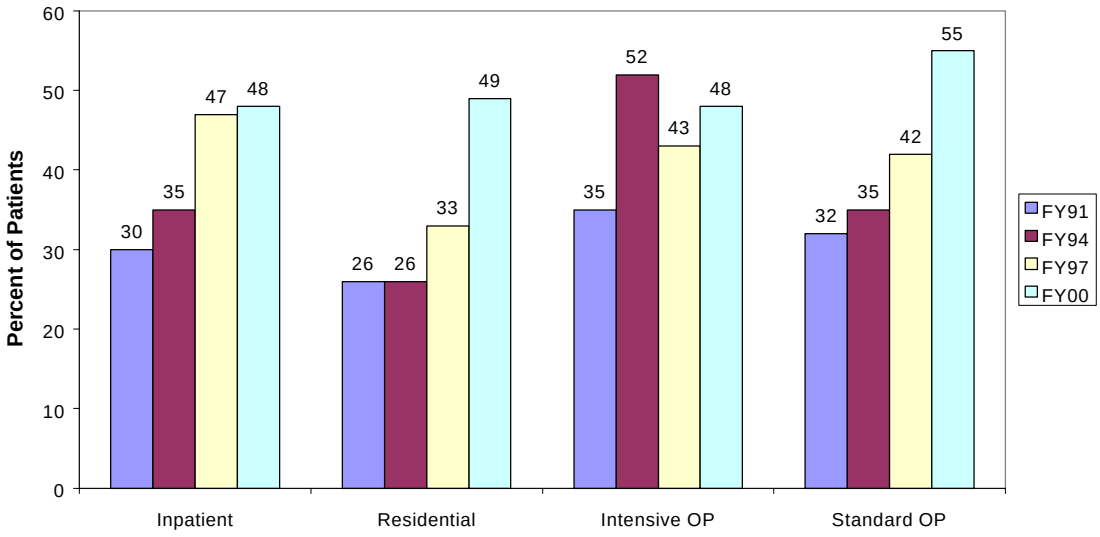


Figure 5: Percent of VA Substance Abuse Patients with a Psychiatric Diagnosis, FY91-FY00



For the first time since FY91, the proportion of patients who are married or in a marriage-like relationship increased in inpatient (from 32% to 39%) and intensive outpatient programs (31% to 35%), indicating that such programs may be attracting more socially stable patients. However, the proportion stayed constant in residential programs and dropped again in standard outpatient programs, from 40% to 36%. Further, in absolute terms, even the proportion of married patients in inpatient programs is low, indicating that VA substance abuse patients remain relatively socially isolated.

The data in Figure 5 present a clearer and worrisome picture: The proportion of patients with serious comorbid psychiatric disorders rose in all program types from FY97 to FY00. This may be because scarce VA services are being focused more exclusively on the most severely impaired patients. It also may be attributable to the contraction of many VA psychiatry services over the past decade (Rosenheck & Horvath, 1998), leading more patients who have psychiatric disorders being treated in addiction programs. Whatever is causing the change, it is clear that, based on psychiatric problems at least, the prognosis of VA substance abuse patients had steadily worsened over the past decade.[4]

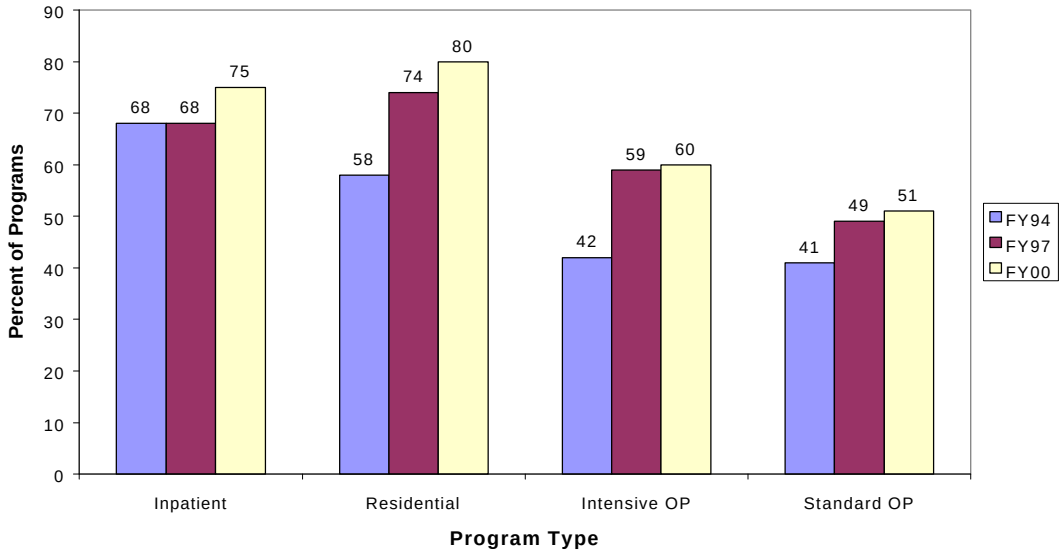
The Content of Treatment

Program structure and accessibility

Patients can only benefit from treatment if they can gain access to it. Accordingly, in FY94 the DAPS began tracking the proportion of programs that were maintaining waiting lists (see Figure 6) on the last day of the fiscal year. In the private sector, only 8% of substance abuse treatment programs have patients on waiting lists on any given day (Roman & Blum, 1997); demand outstrips treatment supply to a much greater extent within the VA. From FY97 to FY00, there were significant increases in the proportion of inpatient programs (68% to 75%) and residential programs (74% to 80%) that had waiting lists. We examined the possibility that this change is due to longer length of stay at such programs, which would increase the time it takes for a bed to become available. The average length of stay in inpatient programs increased slightly from 20 days in FY97 to 23 days in FY00, which may partially account for more inpatient programs maintaining waiting lists. However, the average length of stay in residential programs decreased from 65 days in FY97 to 56 days in FY00, which should have reduced waiting lists. On balance then, the greater prevalence of waiting lists for beds appears more influenced by the declining availability of beds throughout the system rather than by changes in the length of treatment at existent inpatient/residential programs.

Turning to outpatient programs, Figure 6 shows that the proportion of intensive (60%) and standard (51%) outpatient programs maintaining waiting lists remained roughly comparable from FY97 to FY00. This lack of significant change is in itself worth comment, as it represents a flattening of the spike in waiting lists evident at intensive and standard outpatient programs from FY94 to FY97.

Figure 6: Percent of Programs that Maintain a Waiting List, FY94-00



The data in Figure 6 were supplemented with an analysis of the number of patients on waiting lists in FY97 versus FY00 at those programs maintaining waiting lists. This analysis showed little change on the average length of lists at inpatient programs (15 patients in FY97 versus 12 patients in FY00) and residential programs (14 patients in both years). However, the number of veterans on waiting lists in the outpatient sector has increased significantly, with the average list increasing from 6 patients to 11 patients at intensive outpatient programs (83% increase) and from 8 patients to 19 patients at standard outpatient programs (138% increase). Interpreting all the data on waiting lists together, it appears that the contraction of the system from FY97 to FY00 has increased the number of veterans who have to wait for treatment across program types.

Programs were asked whether they ever referred veterans to non-VA substance abuse treatment when they could not themselves accept new patients. Surprisingly, only 25 programs reported that they did so "frequently" or "always". This may be due to poor linkages between VA and non-VA providers. However, it seems more probable that given the substantial contraction in non-VA substance abuse treatment in recent years (D'Aunno & Vaughn, 1995), and the fact that many veterans do not have health insurance, few realistic referral options exist for VA addiction treatment providers whose programs are currently operating at capacity.

Given the foregoing findings, one might wonder whether VA programs are treating similar numbers of patients each year as they have in the past. There was an increase in the average number of admissions per inpatient program (372 in FY97, 427 in FY00) and no change for residential programs (256 in FY97, 258 in FY00). In contrast, intensive outpatient programs declined 14% in average annual number of admissions, from 614 in FY97 to 525 in FY00, and standard outpatient programs declined 13%, from 694 in FY97 to 604 in FY00. These reductions may be due to the increasing number of patients with serious problems being treated in outpatient settings. Such patients, who in prior years would have been treated in residential or inpatient settings, may require more staff resources than patients with less severe disorders.

Treatment Guidelines and Treatment Activities

Clinical practice guidelines are an important recent development in addiction medicine. Such guidelines aid providers in important decisions about treatment, and appear to be having an increasing impact on VA services. In FY00, 79% of program managers reported that they usually based treatment decisions on clinical practice guidelines, a significant increase from FY97 (64% of VA program managers). This increase is likely due to the recent development of draft VA-based guidelines, which are relied upon most commonly (83% of those using guidelines). The other most relied-upon set of guidelines are those of the American Society of Addiction Medicine (69%). Use of these guidelines is comparable to that of private sector providers, 68% of whom rely on ASAM criteria (Roman & Blum, 1997).

Once in treatment, patients may receive medications, psychosocial services, or both. Of medications, opioid agonists (e.g., methadone) deserve detailed attention. In opioid agonist treatment (OAT), such medications are provided along with supportive psychosocial services. OAT has a strong record of effectiveness and has been chosen by the VA Quality Enhancement Research Initiative Substance Abuse Module as a major focus for treatment improvement efforts (QUERI Substance Abuse Module and Executive Committee, 2001). As shown in Table 2, significant portions of patients are dependent on opiates in all program types, and therefore are candidates for OAT. However, only a minority of these patients received OAT.

Table 2: Average Percent of Patients Opiate Dependent and Receiving Methadone/LAAM

Table 2	Inpatient	Residential	Intensive OP	Standard OP
% Opiate Dependent	26	16	17	21
% Methadone	6	1	9	10
% LAAM[5]	0	0	1	5

Fortunately, three important policy changes may increase the ability of VA addiction treatment programs to provide OAT in the future. First, the regulatory burden attached to this therapy has been significantly lessened by recent federal legislation. Second, a new opioid agonist (buprenorphine) that should be useful for some VA patients is nearing federal approval. Third, in the implementation of the Veterans Millennium Health Care Act OAT was prioritized, so a number of VA facilities will receive funds to expand this form of treatment.

FY00 DAPS data on other forms of pharmacotherapy are presented in Table 3. Across settings, psychotropic medications (e.g., SSRIs, atypical antipsychotics) are the most commonly provided form of medication. The proportions reported here are approximately double those reported by programs in the early 1990s (see Humphreys, Dearmin Huebsch, & Moos, 1998). This is not surprising given the recent development of new psychiatric medications, the increasing psychiatric comorbidity of VA substance abuse patients, and the fact that 95 (39%) of the 246 programs operating in FY00 reported that they specialized in treating dually diagnosed patients. By way of comparison, only 8.1% of substance abuse treatment programs in the private sector are designed entirely for such high-severity patients (Roman & Blum, 1997).

Table 3: Average Percent of Patients Receiving Pharmacotherapy

Treatment	Inpatient	Residential	Intensive Outpatient	Standard Outpatient
Naltrexone(Revia)	4	4	4	5
Disulfiram(Antabuse)	4	4	4	7
Medications to aid detoxification from alcohol	42	6	11	7
Psychotropic medications	48	46	32	42
Nicotine patch/gum	19	10	6	6

Medications to aid detoxification (e.g., benzodiazapines) are the second most commonly provided type of pharmacotherapy, followed by nicotine patch/gum. Interestingly, this latter form of treatment has become much more common since the FY97 DAPS was conducted, at which time it was provided to 10% of patients in inpatient settings, and 5% of patients in all other settings. Finally, as in prior years, across program types only a small proportion of patients were prescribed Naltrexone or Disulfiram.

Turning to psychosocial services, Table 4 provides data on five service domains drawn from the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980): Substance abuse, psychiatric, medical, employment/support, and legal. Across program types, substance abuse-related group and individual psychotherapy is provided to almost all VA patients. Most patients in inpatient and residential programs, and a significant minority of patients in outpatient settings, also participate in substance abuse-related self-help groups, such as Alcoholics Anonymous.

In all program types, most VA substance abuse patients receive a psychiatric assessment, and almost half receive psychotherapy specifically focused on psychiatric problems. A minority of patients receives couples or family psychotherapy, which may reflect the social isolation of many VA patients.

Not surprisingly, inpatient and residential services provide the most extensive medical services. However, a significant minority of patients in intensive and standard outpatient addiction treatment programs receives some medical care. Also in line with expectation, employment and support services are provided most commonly in residential programs. The sole exception is financial services (e.g., help obtaining benefits), which are most commonly provided in inpatient programs, perhaps because of the severe disability of patients in these programs. Finally, as in prior years, most programs do not provide legal services themselves, though many refer patients to other VA offices for such services.

Table 4: Average Percent of Patients Participating in Treatment Activities

Treatment Activity	Inpatient	Residential	Intensive Outpatient	Standard Outpatient
Substance Abuse Services:				
Substance abuse-related group or individual psychotherapy	97	92	92	91
Substance abuse-related self-help groups	56	81	46	21
Psychiatric and Family/Social Services:				
Psychological/Psychiatric Assessment	79	74	68	61
Group or individual therapy related to psychiatric problems	45	40	38	41
Couples or family Psychotherapy	17	11	16	10
Medical Services:				
Physical examination	85	84	49	43
Primary care for medical Problems	54	64	42	27
HIV risk reduction counseling/ Education	81	78	75	41
Employment/Support Services				
Vocational rehabilitation or Work training	18	28	13	8
Vocational/Education Counseling	24	44	30	7
Academic education/ GED Classes	8	6	2	1
Financial services	35	17	13	9
Legal Services				
Legal assistance	1	5	3	1

The structure of care across VA Networks

The VHA comprises 22 Veterans Integrated Service Networks (VISNs), each of which has considerable discretion in deciding how to structure health care in the network for the benefit of the covered population. As shown in Table 5, VISNs vary significantly in how they structure addiction treatment. Most notably, at the time of the FY00 DAPS, two Networks had no inpatient or residential programs. This situation may present access difficulties for veterans in these VISNs and for those whose residence is distant from any VA facility or who require 24-hour care. The Veterans Millennium Health Care Act included some funding that may help address these gaps, although the amount was modest compared with that provided under the early 1990s substance abuse enhancement initiative.

The other notable finding in Table 5 is the substantial differences among VISNs in the availability of outpatient care. For example, 5 Networks have 10 or more outpatient programs, whereas 3 other Networks have 3 or fewer such programs. Some evidence indicates that when VA substance abuse services are less available, addicted patients make greater use of costly psychiatric and medical services instead (Humphreys et al., 1997). Whether such a pattern is occurring in those Networks with less services is not known, but it is an important question for network managers to consider when designing a mix of substance abuse services.

Other network-level data aggregated from reporting programs is presented in Table 6. The ratio of patients on waiting lists to existing beds provides an informative measure of supply and demand for addiction care in each Network, and shows substantial variation across Networks. For example, the waiting list for inpatient substance abuse treatment within four Networks approaches or exceeds the total capacity of the network, whereas six other Networks are providing inpatient treatment on demand. In contrast, demand for residential care appears to be outstripping supply in almost all Networks, only three of which have residential beds for which no veteran is waiting.

Table 5: Number of Substance Abuse Programs by Network

Network # Headquarters	Inpatient	Residential	Intensive OP	Standard OP
1 – Boston, MA	1	3	5	10
2 – Albany, NY	1	2	1	2
3 – Bronx, NY	1	5	4	5
4 – Pittsburgh, PA	1	5	1	6
5 – Baltimore, MD	1	2	2	1
6 – Durham, NC	1	4	1	3
7 – Atlanta, GA	0	0	7	2
8 – Bay Pines, FL	0	3	3	5
9 – Nashville, TN	2	0	4	1
10 – Cleveland, OH	1	2	5	6
11 – Ann Arbor, MI	1	1	3	2
12 – Hines, IL	0	12	2	2
13 – Minneapolis, MN	1	4	4	4
14 – Omaha, NE	0	2	2	2
15 – Kansas City, MO	0	1	8	1
16 – Jackson, MS	1	4	4	8
17 – Dallas, TX	1	3	1	0
18 – Phoenix, AZ	1	2	2	3
19 – Denver, CO	0	0	1	3
20 – Portland, OR	4	6	4	10
21 – San Francisco, CA	1	1	5	3
22 – Long Beach, CA	1	2	4	6
Total	20	64	73	85

Table 6: Substance Abuse Beds and Waiting Lists by Network

	Inpatient			Residential		
Network # Headquarters	Beds	# Pts. Waitlist	% Waitlist of Capacity	Beds	# Pts. Waitlist	% Waitlist of Capacity
1 – Boston, MA	10	0	0%	55	14	25%
2 – Albany, NY	24	0	0%	298	0	0%
3 – Bronx, NY	26	0	0%	194	84	43%
4 – Pittsburgh, PA	15	13	86%	175	29	17%
5 – Baltimore, MD	30	0	0%	102	0	0%
6 – Durham, NC	20	6	30%	146	40	27%
7 – Atlanta, GA	NA	NA	NA	NA	NA	NA
8 – Bay Pines, FL	NA	NA	NA	54	71	131%
9 – Nashville, TN	31	5	16%	NA	NA	NA
10 – Cleveland, OH	67	7	10%	79	40	51%
11 – Ann Arbor, MI	18	80	444%	50	76	152%
12 – Hines, IL	NA	NA	NA	349	67	19%
13 – Minneapolis, MN	10	4	40%	207	8	4%
14 – Omaha, NE	NA	NA	NA	27	12	44%
15 – Kansas City, MO	NA	NA	NA	30	3	10%
16 – Jackson, MS	32	0	0%	75	83	111%
17 – Dallas, TX	26	0	0%	148	154	104%
18 – Phoenix, AZ	21	18	86%	90	0	0%
19 – Denver, CO	NA	NA	NA	NA	NA	NA
20 – Portland, OR	36	20	55%	284	26	9%
21 – San Francisco, CA	15	25	166%	70	10	14%
22 – Long Beach, CA	29	5	17%	50	15	30%

Conclusions and Recommendations

From FY97 to FY00, the VA substance abuse treatment system continued a contraction that began in FY95. Although residential programs expanded, all other forms of addiction treatment decreased in availability. Most programs and most networks have significant waiting lists for addiction treatment services.

The problems of VA substance abuse patients appear to have increased over the past decade, especially in terms of psychiatric comorbidity. VA clinicians have responded by increasing their provision of psychiatric services in addiction programs. However, other efforts are needed to aid this vulnerable population of veterans, and indeed all VA substance abuse patients. The recommendations that follow are intended to help realize this goal.

1. Continue to expand residential services. Residential programs offer an inexpensive method for compensating for the loss of inpatient substance abuse beds. Such programs are important because some veterans are homeless or live great distances from VA facilities, and thus cannot easily participate in outpatient care. Further, some addicted veterans have other comorbidities that require more attention and treatment than can be provided on an ambulatory basis. Hence, continuing the expansion of residential programs is an important goal for VA, especially in those Networks where no inpatient substance abuse programs exist.

2. Expand opioid agonist treatment services. Even though methadone maintenance is probably the most effective treatment for opiate dependence, most eligible VA patients do not receive this service. Recent regulatory changes, targeted funds in the Veterans Millennium Health Care Act, and efforts of the QUERI Substance Abuse Module have created the best opportunity in recent years to dramatically expand availability of this treatment, which should literally prove life-saving (Barnett, 1999) for some opiate-dependent veterans.

3. Train staff to better link patients with community resources. The contraction of treatment resources has increased the need for providers to link patients to community resources, such as in the traditional social work approach of working with troubled individuals. Although few clinicians would disagree with the importance of linking patients to community resources, many may not be aware that concrete, empirically-validated ways of doing so exist (e.g., Sisson & Mallams, 1981). Focused training in how to best link patients to self-help groups and other community resources may help make the VA more clinically- and cost-effective (Humphreys & Moos, 2001).

4. Evaluate the impact of the Veterans Millennium Health Care Act. This important legislation will inject new funds in to VA addiction treatment, the first such policy initiative since the substance abuse enhancement program of the early 1990s (Greenbaum et al., 1993). Experience shows that evaluation and monitoring will be necessary to ensure that these new resources are expended on effective treatment for substance abuse. One focus of this monitoring should be to determine whether the amount of funds provided by this act are sufficient to significant improve VA substance abuse treatment, or if further resources will be needed.

Acknowledgments

Elizabeth Oliva and Mark Greenbaum assisted in delivering the DAPS survey and gathering data. John Finney and Rudolf Moos made helpful comments on a draft of this report. Richard Suchinsky provided advice and support throughout all stages of the project.

Notes

1 To the credit of VA program managers, the response rate for the triennial DAPS surveys has averaged 99% since the process began in 1991. In the few cases where a program did not complete the DAPS for a given year, its data was imputed using mean values for other programs of the same type who completed the survey that year.

2 The total number of programs includes "case-finding and early intervention teams", which do not fit into the 4 main program types. Such programs identify and assess veterans who need substance abuse treatment (e.g., patients currently on a medical ward), provide brief transitional interventions, and refer patients to more intensive treatment as warranted. Case-finding teams first began to appear in the VA during FY94, and the first three are described in the PERC report on the DAPS for that year (Humphreys, Hamilton, & Moos, 1996). By FY97, five facilities had such teams, but this number had declined back to 3 by the FY00 DAPS. These three teams had an average FTE of 4.7 and had contact with an average of 546 patients per year, 50% of whom were dually-diagnosed.

3 Condensing this section of the DAPS was part of a general review of the process designed to reduce administrative burden on VA program staff and to increase the efficiency of VA data collection efforts. Overall, the FY00 DAPS was 35% shorter than the FY97 DAPS.

4 PERC analyses of VA databases also showed increases in the proportion of dual-diagnosis patients in inpatient and residential substance abuse programs, but the findings were of smaller magnitude (Piette & Fong, 2000). This difference is due to the DAPS data on comorbidity being based only on serious psychiatric disorders, a subset of all those recorded in the VA databases, and, the DAPS data being based on percentages within each program's caseload rather than percentages within the entire VA health care system.

5 After the FY00 DAPS was completed, the Food and Drug Administration issued a warning that LAAM may have serious adverse side effects in some patients (e.g., cardiac arrhythmia). The potential impact of this warning on the provision of LAAM in the VA will be assessed in future iterations of the DAPS.

References

Barnett, P. G. (1999). The cost-effectiveness of methadone maintenance as a health care intervention. Addiction, 94, 479-488.

Chen, S., Wagner, T. H., & Barnett, P. G. (In press). The effect of reforms on expenditures for substance abuse treatment in the Department of Veterans Affairs: 1993-1999. Health Affairs.

D'Aunno, T., & Vaughn, T.E. (1995). An organizational analysis of service patterns in outpatient drug abuse treatment units. Journal of Substance Abuse, 7, 27-42.

Greenbaum, M.A., Swindle, R. W., & Moos, R. H. (1993). Expanding VA substance abuse services: Fourth year (FY93) program implementation. Palo Alto, CA: Program Evaluation and Resource Center and Center for Health Care Evaluation.

Humphreys, K., Baisden, K., Moos, R. H., & Piette, J. D. (1997). Treatment of VA inpatients with diagnoses of substance abuse. Psychiatric Services, 48, 171.

Humphreys, K., Dearmin Huebsch P., & Moos, R. H. (1998). The Department of Veterans Affairs substance abuse treatment system: Settings, services, staffing and management policies. Palo Alto, CA: Program Evaluation and Resource Center.

Humphreys, K., Dearmin Huebsch, P., Moos, R. H., & Suchinsky, R. T. (1999). The transformation of the VA substance abuse treatment system. Psychiatric Services, 50, 1399-1401.

Humphreys, K., Hamilton, E. G., & Moos, R. H. (1996). Substance abuse treatment in the Department of Veterans Affairs: System Structure, Patients, and Treatment Activities. Palo Alto, CA: Program Evaluation and Resource Center.

Humphreys, K., & Moos, R. H. (2001). Can encouraging substance abuse inpatients to participate in self-help groups reduce the demand for outpatient aftercare?: A quasi-experimental study. Alcoholism: Clinical and Experimental Research, 25, 711-716.

Kizer, K. W. (1996). Prescription for change: The guiding principles and strategic objectives underlying the transformation of the Veterans Healthcare System. Washington, D.C.: Department of Veterans Affairs.

McLellan, A. T., Luborsky, L., Woody, G.E., & O'Brien, C. P. (1980). An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index. Journal of Nervous and Mental Disease, 168, 26-33.

Moos, R. H., Finney, J. W., Federman, E. B., & Suchinsky, R. (2000). Monitoring the quality of substance abuse care: Specialty mental health care improves patients' outcomes. Palo Alto, California: QUERI Substance Abuse Module.

Piette, J. D., & Fong, W. X. (2000). Comparison of utilization in fiscal years 1999, 1998, and 1995. Palo Alto, CA: Program Evaluation and Resource Center.

QUERI Substance Abuse Module and Executive Committee. (2001). Treatment for opiate dependence. VA Practice Matters, 6, 1-6.

Roman, P., & Blum, T. (1997). National treatment center study summary report. Athens, GA: Institute for Behavioral Research, University of Georgia.

Rosenheck, R., & Horvath, T. (1998). The impact of VA reorganization on patterns of mental health care. Psychiatric Services, 49, 53.

Sisson, R. W., & Mallams, J. H. (1981). The use of systematic encouragement and community access procedures to increase attendance at Alcoholics Anonymous and Al-Anon meetings. American Journal of Drug and Alcohol Abuse, 8, 371-376.

Stöffelmayr, B. E., Benishek, L. A., Humphreys, K., Lee, J. A., & Mavis, B. E. (1989). Substance abuse prognosis with an additional psychiatric diagnosis: Understanding the relationship. Journal of Psychoactive Drugs, 21, 145_152.

Substance Abuse and Mental Health Services Administration. (2000). Uniform facilities data set (UFDS): 1998. Rockville, MD: Office of Applied Studies, SAMHSA.

Appendix A: The 2000 Drug and Alcohol Program Survey

A2

2000 DRUG AND ALCOHOL PROGRAM SURVEY

This survey of VA substance abuse treatment programs is being conducted by the Program Evaluation and Resource Center (PERC) for the Mental Health Strategic Healthcare Group at Veterans Affairs Headquarters. **Please complete the survey and return it within two weeks**.

All questions on this survey concern the program listed below. Please check the information on the attached label and make any necessary corrections:

Today's Date: _____

If someone other than the person listed above takes primary responsibility for responding to this survey, please enter his/her information below:

Respondent Name: _____

Job Title:_____

Telephone #: (_____) _____-_____ ext._____

Program Evaluation and Resource Center (152MPD)
VA Health Care System, 795 Willow Road
Menlo Park, CA 94025
(650) 617-2746

A. GENERAL PROGRAM AND PATIENT INFORMATION

1. Which category best describes your program? (CHECK ONE)

   Inpatient or Combined Inpatient and Outpatient…….. ☐ 1

   Outpatient or Intensive Outpatient/Day Treatment……... ☐ 2

   Domiciliary……... ☐ 3

   Residential Rehabilitation (includes CWT/TR/SARRTP/STAR)……..... ☐ 4

   Case-finding and Early Intervention Team……. . ☐ 5

   Detoxification and Stabilization……..… ☐ 6

2. Is your program specifically intended to provide specialized services to substance abuse patients who have serious comorbid psychiatric disorders? No ☐ 0 Yes ☐ 1

If this program offers <u>outpatient services only</u>, skip to question 10 on the next page.

3. How many operational beds did this program have as of September 30, 2000? _____ # of Beds

4. How many of this program's beds were occupied as of September 30, 2000? _____ # of Beds

5. What was this program's average occupancy rate during FY00? _____ % of Beds

6. Has your program had a fixed length of stay for inpatient/residential services at any time in the past two fiscal years? No (Skip to item 8) ☐ 0 Yes ☐

1

7. What was your program's fixed length of stay in FY99 and FY00? (Write NA for a year in which you had none)

	FY99	FY00
Days	_____	_____

8. What was the average length of stay for patients in this program in FY00, not counting time spent in outpatient/aftercare? _____ # of Days

9. How many unique patients were admitted to this program in FY00? (Patients admitted multiple times should be counted only once) _____ # of Patients

If your program offers <u>no outpatient services</u>, please skip to Question 14 on the next page.

10. How many unique patients received outpatient services in this program in FY00? _____
(Patients admitted multiple times should be counted only once) # of Patients

Questions 11a-12b refer to how the OUTPATIENT services (including day hospital and intensive outpatient services) for this program are designed. If the treatment plans vary substantially across patients, please answer these items with reference to how treatment is planned for most of the patients in this program.

11a. In the first week of outpatient treatment, on how many DAYS are patients supposed to receive services from this program? _____
# of Days

11b. Has this number of days changed since FY99? ____No
____Yes, in FY99 it was_____Days

12a. In the first week of outpatient treatment, how many HOURS are patients supposed to receive services from this program on days that they receive treatment? _____
# of Hours

12b. Has this number of hours changed since FY99? ____No
____Yes, in FY99 it was_____Hours

13. Approximately what percentage of <u>outpatients</u> in your program stay overnight in the following types of housing when they are receiving outpatient services:

a. In private residences (including their own residence or that of a friend or relative) _____

b. In on-site VA facilities (e.g., domiciliaries) _____

c. In community-based facilities owned or contracted by the VA (e.g., halfway houses) _____

d. In other community-based facilities (e.g., homeless shelters) _____

ALL PROGRAMS SHOULD ANSWER THE FOLLOWING QUESTIONS

14. As of September 30, 2000, how many veterans were on this program's waiting list, including those waiting for a screening interview? (Indicate NA if this program does not maintain a waiting list) _____ # of Veterans

15. When your program cannot currently accept new patients, how often do you refer veterans to non-VA treatment providers? (CHECK ONE)

N/A, we can always accept new patients…….. ☐ 1

Never……. ☐ 2

Occasionally…….. ☐ 3

Frequently……. ☐ 4

Always…….. ☐ 5

16. Approximately what percent of patients treated in this program in FY00 had the following characteristics at intake: Percent of patients (0-100)

a. Were married or in a long-term, marriage-like relationship?……._____

b. Were female?……._____

c. Had an opiod dependence diagnosis?……._____

d. Had both a substance abuse and a major psychiatric disorder?……._____

17a. Does your program usually base decisions about patients' treatment on clinical practice guidelines? IF NO SKIP TO ITEM 18. No ☐ 0 Yes ☐ 1

17b. Please indicate which practice guidelines this program uses (CHECK ALL THAT APPLY):

a1. American Society of Addiction Medicine……... ☐ 1

a2. American Psychiatric Association……... ☐ 1

a3. Center for Substance Abuse Treatment……... ☐ 1

a4. Department of Veterans Affairs…….. ☐ 1

a5. Another set of guidelines (please specify)_____ ☐ 1

B. TREATMENT SERVICES

18. Below is a list of treatment services this program may provide. For each type of service indicate the estimated percentage of patients who receive the service directly from program staff (i.e., do not report services provided to your patients by other VA or non-VA programs). Where applicable, please also indicate the average number of hours per week each activity is provided to those patients receiving that service.

		Percent of Patients Receiving this Service From this program	Average Number of Hours per Week
a.	Substance abuse-related self-help groups (e.g., AA, NA)	_____	a1. _____
b.	Substance abuse-related group or individual psychotherapy	_____	b1. _____
c.	HIV risk reduction counseling/education	_____	c1. _____
d.	Primary care for medical problems	_____	d1. _____
e.	Physical examination	_____	e1. _____
f.	Couples or family psychotherapy/counseling	_____	f1. _____
g.	Psychological/Psychiatric assessment	_____	g1. _____
h.	Group or individual therapy related to psychiatric problems	_____	h1. _____
i.	Academic education/GED classes	_____	i1. _____
j.	Legal services	_____	j1. _____
k.	Financial services (e.g., help obtaining benefits)	_____	k1. _____
l.	Vocational rehabilitation or work training	_____	l1. _____
m.	Vocational/Educational counseling	_____	m1. _____
n.	Methadone	_____	NA
o.	Levo-alpha-acetyl-methadol (LAAM)	_____	NA
p.	Naltrexone	_____	NA
q.	Buprenorphine	_____	NA
r.	Antabuse (Disulfiram)	_____	NA
s.	Medication to aid detoxification from alcohol	_____	NA
t.	Psychotropic medication (e.g., anti-depressants)	_____	NA
u.	Breathalyzer test	_____	NA
v.	Nicotine patch/gum	_____	NA

C. STAFFING

For all questions in this section, count only paid staff, not volunteers.

STAFF CUTS:

19. Since **October 1, 1999** has this program experienced any cuts in FTEE? No ☐ 0 Yes ☐ 1

If NO, please skip to Question 28 on the next page.
If YES, please list each position/job title that was cut, and its FTEE in this program.

Position/Job Title (e.g., Psychiatrist, RN, Addiction Counselor)	**FTEE**
20.	
21.	
22.	
23.	
24.	
25.	
26.	
27. Total FTEE Cut	

CURRENT STAFF LISTING:

28. Please list the total FTEE in this program for each job title as of October 1, 2000. Include those positions which are vacant if you are currently recruiting for them. If any of this program's positions are not listed, please include them under "All other staff" at the end of the list.

Position/Job Title	FTEE In this Program
a. Psychiatrist	
b. Physician (non-psychiatrist)	
c. Psychologist (Ph.D. or Psy.D.)	
d. Physician Assistant	
e. RN, Clinical Nurse Specialist, Nurse Practitioner	
f. LP Nurse, LV Nurse	
g. Nursing Assistant	
h. Social Worker (MSW, CSW, ACSW etc.)	
i. Addiction Therapist/Counselor (non-MSW)	
j. Psychology/Social Work/ Rehabilitation Tech or Aide	
k. Pharmacist	
l. Recreational Therapist	
m. Vocational Rehabilitation Specialist	
n. Secretary, Administrative Assistant, Clerk	
o. All other staff	
p. TOTAL FTEE IN THIS PROGRAM	

STAFF ADDITIONS:

29. Since **October 1, 1999** has this program experienced any **increases** in FTEE?

N/A Program didn't exist ☐ 0
No ☐ 1
Yes ☐ 2

If NO, please skip to Question 36, below.
If YES, please list each position/job title that was added and its FTEE in this program.

Position/Job Title (e.g., Psychiatrist, RN, Addiction Counselor)	**FTEE**
30.	
31.	
32.	
33.	
34.	
35. Total FTEE Added	

36. In terms of the number of patients you expect your program to treat next fiscal year, do you think it will be:

(CHECK ONE)

About the same as it was this past FY…….. ☐ 1
Significantly more than this past FY…….. ☐ 2
Significantly less than this past FY……... ☐ 3

Thank you. You are finished. Please make a copy of the survey for your records and return the completed survey to PERC in the enclosed envelope.